STATEMENT OF CLAIM FOR GROUP VISION BENEFITS

RETURN COMPLETED FORM TO:

GREATER KANSAS CITY LABORERS WELFARE FUND
6405 Metcalf, Suite 200
Overland Park, Kansas 66202
(913) 236-5490

Please check if new address ☐

MEMBER MUST COMPLETE THIS SECTION IN FULL

Member's Full Name	Member's Marital Status: M / S / Wid. / Div. / Leg. Sep.	☐ Male ☐ Female	Date of Birth	Social Security No.
Home Address (Number and Street)	(City)	(State)	(Zip Code)	Telephone No.
Patient's Full Name	Patient's Marital Status: M / S / Wid. / Div. / Leg. Sep.	☐ Male ☐ Female	Date of Birth	Relationship to Member

Was there an accident? ☐ Yes ☐ No	Date accident occurred	Time: ☐ A.M. ☐ P.M.	Was patient at work when the injury/accident occurred? ☐Yes ☐ No

Describe accident (Tell how, when and where it occurred)

Is this patient covered under any other group health plan? ______Yes ______No
If yes, please complete:
Name of Insured______________________________
Name of group (employer or union)
through which cover is provided______________________________
Name and Address of the office where claims are paid______________________________

The policy or identification number______________________________
NOTE: If possible, attach copy of payments made by other company.

MEMBER'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize any physician, hospital, insurer or other organization or person maving any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such company to the Laborers Welfare Plan. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

REMEMBER TO ATTACH ITEMIZED BILLS

Signed______________________________
Address/City______________________________
Dated______________________________

FORM 7/94

A CLAIM FORM MUST BE FILED FOR EACH INJURY OR ILLNESS

TO BE COMPLETED BY DOCTOR (List Charges)

Name of Patient (Please Print)		Birth Date of Patient Month Day Year
Date of Examination Month Day Year	Date of Patient's Last Examination Month Day Year	Charges for Examination $

Diagnosis:

Remarks:

Doctor's Name (Please Print)	Degree	License Number

Doctor's Address — Telephone

City — State — Zip

Doctor's Signature — IRS #

TO BE COMPLETED BY OPTOMETRIST OR OPTICIAN'S OFFICE

Name of Person for whom services were rendered (Please Print)

Date Services Provided Month Day Year	Lens Type (Circle One) SINGLE TRIFOCAL BIFOCAL CONTACT	Charge for Lenses $	Charge for Frames $

Optical Agency Name (Please Print)	Signature of Supplier
Address	
City State Zip	and Title

I hereby certify that the services listed above have been performed.
DOCTOR/
OPTOMETRIST/
OPTICIAN's
Signature____________________ Date____________